

Carer Counselling Program – Victoria

A Commonwealth Government Initiative



EXPRESSION OF INTEREST – CONTRACT COUNSELLOR

Counsellor Details (please provide copies of all relevant documentation)

Individual / Business Name _____

ABN Number _____

Postal Address _____

Phone No _____ Fax No _____ Email _____

Practice address/es and availability details _____

Practice Profile

Current services provided _____

Current sources of referrals _____

Years in operation _____

Supervision arrangements (include qualifications of supervisor and frequency) _____

Details of current insurance cover policies _____

A) Professional Indemnity _____

B) Public Liability _____

Details of current Police and Working with Children's Checks _____

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Professional Qualifications

(Please provide details of any relevant tertiary qualifications)

Institution _____
_____ Date _____

Institution _____
_____ Date _____

Institution _____
_____ Date _____

Institution _____
_____ Date _____

Professional Registration/Membership

(Please provide details and attach copies of relevant Professional bodies that you are registered with or have membership with currently)

Medicare Registration (Please provide details if applicable) _____

Professional Experience

Details of supervised counselling experience _____

Details of areas of counselling specialisation _____

Details of preferred client groups _____

Details of key counselling frameworks _____

Details of any other current employment _____

Details of any relevant previous employment _____

Please provide information about your current and previous work with carers and caring related issues _____

Please outline any knowledge of specific cultural communities or language fluency that you have _____

Referees

Please supply the names and contact details of at least two referees who can comment on your counselling experience

Referee 1 (Please include the nature and period of relationship) _____

Referee 2 (Please include the nature and period of relationship) _____

Signature of Applicant _____

Date

Return to: CC&AS Program Manager
Carers Victoria
P O Box 2204
FOOTSCRAY VIC 3011
or by Fax: 9396 9595